

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2014
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350
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R000000	<p>This visit was for the Investigation of Complaint IN00144886.</p> <p>Complaint IN00144886-Substantiated. State residential deficiencies related to the allegations are cited at R0029, R0041, and R0053.</p> <p>Survey date: February 28, 2014</p> <p>Facility number: 010890 Provider number: 010890 AIM number: N/A</p> <p>Survey team: Janelyn Kulik, RN-TC</p> <p>Census bed type: Residential: 113 Total: 113</p> <p>Census payor type: Other; 113 Total: 113</p> <p>Sample: 3</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on March 4, 2014, by Brenda Meredith, R.N.</p>	R000000	<p><i>We respectfully request a desk review. Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, record review and interview, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed for abuse related to a staff member yelling and cursing at a resident. (Resident #C and CNA #2)</p> <p>Findings include:</p> <p>On 2/28/14 at 8:20 a.m., during the initial tour with the Resident Care Director (RCD), Resident #C was observed sitting in the dining room waiting for breakfast to be served. At this time the RCD indicated there had been an incident of alleged verbal abuse against Resident #C. She further indication two CNAs were terminated due the allegation of abuse. She indicated at this time one CNA was terminated for being verbally abusive and the other CNA was terminated for not reporting the</p>	R000029	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i> Resident C has significant dementia and on interview after the incident did not remember the incident. The resident had been monitored for signs and symptoms of distress and none have been noted. CNA1 and QMA1 were placed on administrative leave upon the Executive Director being notified of the incident and an investigation was initiated. CNA1 and QMA1 are no longer working at the community.</p> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i> Residents and staff were interviewed following the incident and no further incidents or concerns were reported. Staff was retrained on Abuse/</p>	03/31/2014
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	<p>verbal abuse immediately. The RCD further indicated Resident #C was not interviewable.</p> <p>The Resident's record was reviewed on 2/28/14 at 10:35 a.m. The Resident's diagnoses included, but were not limited to, dementia, hypertension, anemia, and osteoarthritis.</p> <p>A service note, dated 1/19/14 at 8:10 a.m., indicated event charging, the Resident did not recall being spoken to rudely from 1/18/14. The incident was reported to the Executive Director, Resident's son, and the doctor. The staff will continue to monitor the Resident for adverse effects.</p> <p>On 2/28/14 at 12:30 p.m., review of an Indiana State Department of Health Reportable Incident form indicated, on 1/1/8/14 at 1:15 p.m., CNA #2 had been verbally abusive to Resident #C and CNA #3 had witnessed the event.</p> <p>On 2/28/14 at 3:30 p.m., the Executive Director provided the Termination of Employment form for CNA #2. The form indicated the description of the issues leading to the termination was yelling and</p>		<p>Neglect and Reportable Events. A retraining has been scheduled for all staff on Resident Rights, including the right to be treated with respect and dignity. The community will invite the Ombudsman to complete a further retraining in the next quarter.</p> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <p>The Executive Director/designee will review associates files for completion of the required re-trainings. The Executive Director/ designee will review new associate files for completion of Abuse, Neglect, Reportable Events and Resident Rights including the right to be treated with respect and dignity, training. The Executive Director/ designee will complete 3 random supervisory visits during care provision weekly, rotating shifts for three months to observe for compliance with Resident Rights. The CQI committee will review results and discuss next steps as warranted. If at the end of three months there are no issues noted the committee will consider whether continued observations are warranted. If there are issues, the CQI committee will extend for three months and re-evaluate. The Community CQI committee will complete 5 random audits of associate files for completion of required training related to Resident Rights,</p>				

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	<p>cursing at a resident on 1/18/14. This form was dated 1/21/14.</p> <p>On 2/28/14 at 9:19 a.m., the facility policy for "Residents' Rights" was reviewed. The policy included, but was not limited to, "Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality." It also indicated, "Residents have the right to be free from verbal abuse."</p> <p>During an interview with the Executive Director and RCD on 2/28/14 at 3:30 p.m. the Executive Director indicated CNA #2 had been verbally abusive to Resident #C. She further indicated CNA #3 had witness the abuse and it not immediately report the incident. She also indicated the facility had a zero tolerance for abuse and that staff must immediately report and suspected abuse.</p>		Abuse / Neglect and reportable events quarterly for one year and follow up as necessary.				

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R000041	<p>410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals.</p> <p>Based on observation, record review and interview, the facility failed to ensure their Abuse and Residents' Rights policy was implemented for 2 of 3 residents reviewed for allegations of abuse related to a substantiated allegation of abuse and employees failing to report allegations of abuse immediately. (Resident #B, Resident #C, QMA #1, CNA #1, CNA #2 and CNA #3)</p> <p>Finding include:</p> <p>1. On 2/28/14 at 8:20 a.m., during the initial tour with the Resident Care Director (RCD), Resident #B was observed sitting in the dinning room waiting for breakfast to be served. At this time the RCD indicated there had been an allegation of verbal abuse that was unsubstantiated, however an employee failed to report the allegation immediately and was</p>	R000041	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i> Resident B has significant dementia and on interview was not able to recall the incident. The resident had been monitored for signs and symptoms of distress and none have been noted. . CNA1 and QMA1 were placed on administrative leave upon notification of the Executive Director of the incident and an investigation initiated. CNA1 and QMA1 are no longer working at the community.</p> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i> Residents and staff were interviewed following the incident and no further incidents or concerns were reported. Staff was retrained on Abuse/ Neglect and Reportable Events. A retraining has been scheduled for all</p>	03/31/2014			

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	<p>terminated. The RCD also indicated the resident was not interviewable.</p> <p>On 2/28/14 at 10:00 a.m., Resident #B was observed walking in the lobby by the Nurses' Station. The Resident was observed repeating whatever was said to her.</p> <p>The record for Resident #B was reviewed on 2/28/14 at 10:05 a.m. The Resident's diagnoses included, but were not limited to, Alzheimer's Disease with anxiety, hypothyroidism (the thyroid gland not functioning properly), and Gastroesophageal Reflux Disease (GERD).</p> <p>On 2/28/14 at 3:30 p.m. an Indiana State Department of Health Reportable Incident form provided by the Executive Director was reviewed. The form indicated it was the initial and follow up of an incident that occurred on 1/18/14 at 11:15 a.m. between Resident #B and QMA #1. A Brief Description of the Incident: "On January 26, 2014 (QMA #1's name) was in the room with the (sic) told the resident come on you need to take a bath. You stink. Don't you want to take a bath? (QMA #1's name) said this in a loud voice."</p>		<p>staff on Resident Rights. The community will invite the Ombudsman to complete a further retraining in the next quarter.</p> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <p>The Executive Director/designee will review associate files for completion of the required re-trainings. The Executive Director/designee will review new associate files for completion of Abuse, Neglect, Reportable Events and Resident Rights training. The Executive Director/ designee will complete 3 random supervisory visits during care provision weekly, rotating shifts for three months to observe for compliance with Resident Rights. The CQI committee will review results and discuss next steps as warranted. If at the end of three months there are no issues noted the committee will consider whether continued observations are warranted. If there are issues, the CQI committee will extend for three months and re-evaluate. The Community CQI committee will complete 5 random associate files for completion of required training related to Resident Rights, Abuse / Neglect and reportable events quarterly for one year and follow up as necessary.</p>				

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	<p>The investigation portion of the incident was reviewed on 2/28/14 at 3:35 p.m. A typed form, dated 2/27/14, indicated, "On Saturday January 26, 2014 I was in the 400 hall and (name of QMA #1) was in the room with the resident (Resident #B) in (Resident #B's room number) and told the resident come on you need to take a bath. You stink. Don't you want to take a bath? (QMA #1's name) said this in a loud voice. This was around 7 p.m. when I witnessed the verbal interaction. I didn't report this to the RCD until the RCD came on duty Sunday. The RCD stated "I'm here until 6:00 tonight." (CNA #1's name) never reported to the RCD what she heard. The first report was to the ED on Monday January 27, 2014 at 11:15." The form was signed by CNA #1 and dated 1/2714.</p> <p>On 2/28/14 at 3:30 p.m., during an interview with the Executive Director and RCD, the RCD indicated CNA #1 told her she needed to talk to her the day after the incident happened. The RCD indicated she had informed CNA #1 that she would be in the facility until 6:00 p.m. and the CNA# never discussed any allegations of abuse with her. She</p>		<p><i>By what date will these systemic changes be implemented?</i></p>	
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	<p>indicated CNA #1 did not report the allegation until the next day, two days after it happened. The Executive Director indicated she felt the CNA was not sure if it was really abuse on not and then decided to report the incident. The Executive director further indicated they have a no tolerance for abuse and the CNA #1 was terminated due to not reporting an allegation of abuse timely.</p> <p>2. On 2/28/14 at 8:20 a.m., during the initial tour with the Director of Resident Care Director (RCD), Resident #C was observed sitting in the dining room waiting for breakfast to be served. At this the RCD indicated there had been an incident of alleged verbal abuse against Resident #C. She further indicated two CNAs were terminated due the allegation of abuse. She indicated one CNA was terminated for being verbally abusive and the other CNA was terminated for not reporting the verbal abuse immediately. The RCD further indicated Resident #C was not interviewable.</p> <p>The Resident's record was reviewed on 2/28/14 at 10:35 a.m. The Resident's diagnoses included, but were not limited to, dementia,</p>						

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	<p>hypertension, anemia, and osteoarthritis.</p> <p>A service note, dated 1/19/14 at 8:10 a.m., indicated event charting, the Resident did not recall being spoken to rudely from 1/18/14. The incident was reported to the Executive Director, Resident's son, and the Doctor. The staff will continue to monitor the Resident for adverse effects.</p> <p>The facility provided an Indiana State Department of Health Reportable form. The form was reviewed on 2/28/14 at 12:30 p.m. The form indicated it was a follow up report, dated 1/21/14. The form further indicated an incident occurred on 1/1/8/14 at 1:15 p.m. The brief description of the incident: CNA #2 had been verbally abusive to Resident #C and CNA #3 had witnessed the event.</p> <p>Review of an Indiana State Department of Health Reportable form provided by the State Department of Health, on 2/28/14 at 1:56 p.m., indicated this form was the initial and follow of an incident and was dated 1/19/14. The form further indicated an incident occurred on 1/18/14 at 1:15 p.m. A</p>			

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	<p>brief description of the incident: CNA #3 reported on 1/19/14 at approximately 6:25 a.m. that yesterday at 1:15 p.m. she was assisting CNA #2 with providing incontinent care to Resident #C, at this time she heard CNA #2 being abusive to Resident #C.</p> <p>On 2/28/14 at 3:30 p.m., the Executive Director provided the Termination of Employment form for CNA #2. The form indicated the description of the issues leading to the termination was yelling and cursing at a resident on 1/18/14. This form was dated 1/21/14.</p> <p>On 2/28/14 at 3:30 p.m., the Executive Director provided the Termination of Employment for CNA #3. The form indicated the description of the issues leading to the termination was, "Witnessed employee yelling and cursing at a resident on 1/18/14. Didn't report to supervisor. (CNA #3's name) states in written statement (name of CNA #2) would yell that's enough, hush, or shut up, I don't want to hear it. It's not my fault you sh-- all over and would yell this in her face. This happened every time we had to take (Resident #C's room number) to the bathroom which was 3 or 4 times</p>			

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	<p>and each time the same thing occurred."</p> <p>The Abuse Policy was provided by the RCD on 2/28/14 at 8:15 a.m. The policy indicated it was, "To protect residents from physical, mental, fiduciary (financial), sexual, and verbal abuse or neglect." The facility also indicated "Community employees are mandated reporters so may report any known or suspected resident abuse, neglect or exploitation without fear of reprisal, retaliation, disciplinary action or termination. Alleged or suspected abuse, neglect or exploitation should be immediately reported to the required state agencies, regardless of the length of time since the alleged occurrence took place. Reports should be made immediately to the Executive director, resident Care Director or other appropriate supervisory personnel."</p> <p>On 2/28/14 at 9:19 a.m., the facility policy for "Residents' Rights" was reviewed. The policy included, but was not limited to, "Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality." It also indicated,</p>			

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R000053	<p>"Residents have the right to be free from verbal abuse."</p> <p>On 2/28/14 at 3:30 p.m., during an interview with the Executive Director and RCD, the Executive Director indicated CNA #2 had been verbally abusive to Resident #C. She further indicated CNA #3 had witness the abuse and it not immediately report the incident. She also indicated the facility had a zero tolerance for abuse and that staff must immediately report and suspected abuse.</p> <p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident #C, CNA #2 and CNA #3)</p> <p>Findings include:</p> <p>During the initial tour on 2/28/14 at 8:20 a.m. with the Director of Resident Care Director (RCD), Resident #C was observed sitting in</p>	R000053	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident C has significant dementia and on interview did recall the incident. The resident had been observed for signs and symptoms of distress and none have been noted. . CNA1 and QMA1 were placed on administrative leave upon notification of the Executive Director of the incident and an investigation initiated. CNA1 and QMA1 are no longer working at the</p>	03/31/2014

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	<p>the dining room waiting for breakfast to be served. At this time the RCD indicated there had been an incident of alleged verbal abuse against Resident #C. She further indicated two CNAs were terminated due the allegation of abuse. She indicated one CNA was terminated for being verbally abusive and the other CNA was terminated for not reporting the verbal abuse immediately. The RCD further indicated Resident #C was not interviewable.</p> <p>The Resident's record was reviewed on 2/28/14 at 10:35 a.m. The Resident's diagnoses included, but were not limited to, dementia, hypertension, anemia, and osteoarthritis.</p> <p>A service note, dated 1/19/14 at 8:10 a.m., indicated event charting, the Resident did not recall being spoken to rudely from 1/18/14. The incident was reported to the Executive Director, Resident's son, and the Doctor. The staff will continue to monitor the Resident for adverse effects.</p> <p>The facility provided an Indiana State Department of Health Reportable form. The form was reviewed on 2/28/14 at 12:30 p.m.</p>		<p>community.</p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Residents and staff were interviewed following the incident and no further incidents or concerns were reported. Staff was retrained on Abuse/Neglect and Reportable Events. A retraining has been scheduled for all staff on Resident Rights. The community will invite the Ombudsman to complete a further retraining in the next quarter.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? The Executive Director/designee will review associates files for completion of the required re-trainings. The Executive Director/ designee will review new associate files for completion of Abuse, Neglect, Reportable Events and Resident Rights training. The Executive Director/ designee will complete 3 random supervisory visits during care provision weekly, rotating shifts for three months to observe for compliance with Resident Rights. The CQI committee will review results and discuss next</p>		

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	<p>The form indicated it was a follow up report, dated 1/21/14. The form further indicated an incident occurred on 1/1/8/14 at 1:15 p.m. The brief description of the incident: CNA #2 had been verbally abusive to Resident #C and CNA #3 had witnessed the event.</p> <p>Review of an Indiana State Department of Health Reportable form provided by the State Department of Health, on 2/28/14 at 1:56 p.m., indicated this form was the initial and follow of an incident and was dated 1/19/14. The form further indicated an incident occurred on 1/18/14 at 1:15 p.m. A brief description of the incident: CNA #3 reported on 1/19/14 at approximately 6:25 a.m. that yesterday at 1:15 p.m., she was assisting CNA #2 with providing incontinent care to Resident #C, at this time she heard CNA #2 being abusive to Resident #C.</p> <p>On 2/28/14 at 3:30 p.m., the Executive Director provided the Termination of Employment form for CNA #2. The form indicated the description of the issues leading to the termination was yelling and cursing at a resident on 1/18/14. This form was dated 1/21/14.</p>		<p>steps as warranted. If at the end of three months there are no issues noted the committee will consider whether continued observations are warranted. If there are issues, the CQI committee will extend for three months and re-evaluate. The Community CQI committee will complete 5 random associate files for completion of required training related to Resident Rights, Abuse / Neglect and reportable events quarterly for one year and follow up as necessary.</p>				

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	<p>On 2/28/14 at 3:30 p.m., the Executive Director provided the Termination of Employment for CNA #3. The form indicated the description of the issues leading to the termination was, "Witnessed employee yelling and cursing at a resident on 1/18/14. Didn't report to supervisor. (CNA #3's name) states in written statement (name of CNA #2) would yell that's enough, hush, or shut up, I don't want to hear it. It's not my fault you sh-- all over and would yell this in her face. This happened every time we had to take (Resident #C's room number) to the bathroom which was 3 or 4 times and each time the same thing occurred."</p> <p>The Abuse Policy was provided by the RCD on 2/28/14 at 8:15 a.m. The policy indicated it was, "To protect residents from physical, mental, fiduciary (financial), sexual, and verbal abuse or neglect." The facility also indicated "Community employees are mandated reporters so may report any known or suspected resident abuse, neglect or exploitation without fear of reprisal, retaliation, disciplinary action or termination. Alleged or suspected abuse, neglect or</p>						

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	<p>exploitation should be immediately reported to the required state agencies, regardless of the length of time since the alleged occurrence took place. Reports should be made immediately to the Executive director, resident Care Director or other appropriate supervisory personnel."</p> <p>On 2/28/14 at 9:19 a.m., the facility policy for "Residents' Rights" was reviewed. The policy included, but was not limited to, "Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality." It also indicated, "Residents have the right to be free from verbal abuse."</p> <p>During an interview with the Executive Director and RCD on 2/28/14 at 3:30 p.m., the Executive Director indicated CNA #2 had been verbally abusive to Resident #C. She further indicated CNA #3 had witness the abuse and it not immediately report the incident. She also indicated the facility had a zero tolerance for abuse and that staff must immediately report and suspected abuse.</p>						